

Busse and colleagues¹ suggest. We do not recommend load-bearing MRI for clinical use in the investigation of low-back pain. We clearly state “evidence is insufficient to support widespread adoption.”⁵

Busse and colleagues¹ refer to two randomized controlled trials that compare vertebroplasty to a sham procedure.^{8,9} Both of these trials have been criticized as deeply flawed by many,¹⁰ including an author of one of the trials.¹¹ The authors¹ ignore the larger and better designed VERTOS II trial,¹² consensus statements from the major societies and organizations representing those who actually perform the procedure, as well as the great preponderance of evidence in its favour.

Busse and colleagues¹ note the substantial controversy over the utility of selective nerve-root blocks and radiofrequency denervation for back pain. When evaluating the literature, one must be conscious of the significant heterogeneity that is inherent in terms of patient back-pain etiology. Interventional procedures likely will not be efficacious when indiscriminately applied to nonspecific back pain. Rather, a better understanding of the types of back pain may lead to the ability to selectively choose those who will benefit the most from particular procedures.

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Clarification of Borod's comments about Bill 52

Physicians may be reluctant to grant interviews about complex issues and concerned that their thoughts may be oversimplified or misrepresented. The *CMAJ* news article about Bill 52¹ is a case in point. I was pleased that the definition of palliative care was changed to be consistent with the World Health Organization definition, to clearly state that palliative care “neither hastens nor postpones death.” It should follow from this that euthanasia is clearly not part of palliative care. I expressed concern that Bill 52 would create more barriers to referral to palliative care — not because of “increased paperwork” but because patients would be reluctant to see physicians who actively terminate patients’ lives. I also expressed concern that although using the term “palliative sedation” as opposed to “terminal sedation” is important, reporting medical acts such as sedation may lead to a reluctance to implement this therapy. My comments were specific to the role of palliative care with regard to Bill 52. To be clear, I do not think that euthanasia or “aid in dying” has any place whatsoever in the practice of palliative care.

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Post-tussive carotid artery dissection: Could it be whooping cough?

I thank Furlan and Sundaram¹ for their interesting case report on a patient who experienced a carotid artery dissection and subsequent Horner syndrome from coughing. I would like to remind clinicians that such a post-tussive injury should prompt consideration of pertussis as an underlying cause.

The cough caused by *Bordetella pertussis* infection is especially violent and can cause a variety of post-tussive injuries. Carotid artery dissection as a complication of pertussis has previously been reported.² Other potential symptoms and injuries secondary to pertussis include prolonged cough, seizures, syncope, encephalopathy, urinary incontinence, rib fracture, pneumothorax, inguinal hernia, subconjunctival hemorrhage, hearing loss and lumbar disc herniation.² In my emergency medicine practice, I have also seen pertussis cause vocal cord dysfunction, post-tussive vomiting and valsalva retinopathy.

The incidence of pertussis has been increasing since 1990.³ We must remain vigilant for it in cases of unusual injury secondary to coughing.

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Unusual venous thrombosis

In a *CMAJ* practice article, Schattner¹ provides guidance regarding when to test for thrombophilia and when to screen for occult cancer in patients with unprovoked venous thromboembolism (VTE). This issue is important, because unprovoked VTE is common (about

20 000 cases a year in Canada),² and indiscriminate thrombophilia testing and extensive cancer screening occur frequently in clinical practice. We wish to emphasize two points. First, thrombophilia testing should be avoided because it does not affect clinical management in most patients.^{3,4} Even if a thrombophilic abnormality is found, such as the factor V Leiden or prothrombin mutation, its presence does not affect risk for recurrent VTE and, therefore, does not affect decisions about continuing or stopping anticoagulation therapy. Exceptions to this premise occur; the antiphospholipid antibody syndrome or protein S or C deficiency will warrant long-term anticoagulation, but such cases are rare (< 5%). Overall, testing for thrombophilia rarely affects patient management, often yields false positive results and may adversely influence insurability of patients. We urge clinicians to consult colleagues with expertise in thrombosis before testing for thrombophilia.

Second, although screening for cancer (i.e., abdominopelvic CT, colonoscopy) may increase the number of cancers detected, it does not appear to improve cancer-related mortality, morbidity or quality of life.⁴ Moreover, such screening may incur procedure-related complications and psychological burden from false positive results.⁵ Ongoing randomized trials are assessing the risks and benefits of comprehensive screening for cancer in unprovoked VTE (NCT00773448, NCT01107327). In the meantime, we suggest age- and sex-appropriate screening for cancer, with additional testing only if patients have symptoms that are suspicious for malignant disease.

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The benefit of stimulants in reducing driving risk in adult drivers with ADHD

Redelmeier and Tien¹ have provided an excellent update on the medical interventions to reduce driving risk. A recent article by Chang and colleagues² from Sweden may be of interest to *CMAJ* readers. The authors reported on an epidemiologic study between 2006 and 2009 of over 17 000 drivers with attention-deficit/hyperactivity disorder (ADHD). The hazard ratio for serious motor vehicle collisions for drivers with ADHD was 1.47, for males and 1.45, for females. The authors observed a 58% risk reduction in motor vehicle collisions involving male drivers with ADHD who took stimulants over the three years of the study. However there was no apparent benefit for female drivers with ADHD. The association between ADHD and increased driving risk, and the protective benefits of stimulants when driving has been documented.³ The *CMA Driver's Guide: Determining Medical Fitness to Operate Motor Vehicles. 8th Edition* includes

ADHD as a reportable condition if there is demonstrated problem driving.⁴ Physicians are encouraged to consider a trial of long-acting stimulants in reducing driving risk. The article by Chang and colleagues² provides more support for this medical intervention in drivers with ADHD and problem driving.

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Letters to the editor

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CORRECTION

"Pharmacist-led group"

A research article that appeared in the May 13, 2014, issue of *CMAJ* contains an error in the last sentence of the Results section, under the heading "Other outcomes." The sentence should read "At 6 months, 58.9% of patients in the pharmacist-led group [not the physician-led group] were taking a statin (32.7% at maximal daily dose) compared with 56.3% (25.8% at maximal dose) in the nurse-led group ($p = 0.7$ for usage, $p = 0.2$ for dosing)." *CMAJ* apologizes for this error.

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